County of Los Angeles – Department of Mental Health

PRACTITIONER ENROLLMENT AND MAINTENANCE FORM
for Fee-For-Service Inpatient Providers

Date Submitted: ___/___/_____ Request Type: ☐ New ☐ Update ☐ Name Change

Practitioner Information

Last Name_____ First Name_____ M_____

Gender ☐ Male ☐ Female ☐ Unknown Ethnicity*_____

Language(s)*_____

Assigned Location Information

Facility Name_____ Facility Code__ __ __ __ __

Address _____ Suite/Floor _____

City_____ Zip Code __ __ __ __ __ - __ __ __ __

Telephone (_____)_____ Email Address_____@_____

Credential Information

Discipline_____ Practitioner Category_____

Categories for Coverage*_____ Practitioner Credential*_____

Taxonomy Description*_____ Taxonomy Code* __ __ __ __ __ __ __ __ __ __

NPI __ __ __ __ __ __ __ __ __ __

Professional License# __ __ __ __ __ __ __ __ __ __ __Eff Date ___/___/_____ Exp Date___/___/_____

DEA License# __ __ __ __ __ __ __ __ __ __ __ Expiration Date __/__/____

Program Association

Add ☐ Effective Date __/__/____ Remove ☐ Effective Date ___/___/_____

Program Name_____ Program Code__ __ __ __ __

Add ☐ Effective Date ___/___/_____ Remove ☐ Effective Date ___/___/_____

Program Name_____ Program Code__ __ __ __ __

Contact Information and Authorized Signature

Authorized Manager_____ Signature_____

Form Completed By_____ Date Processed ___/___/_____

**See Codes Page.*

Rev 4/7/2014